Confirmation of Receipt of Enrollment Form

Dear {insert beneficiary name}:

We have approved your application to our plan. Thank you for choosing {insert organization and/or plan name} as your Medicare plan.

> <u>Note 1:</u> *All closed network plans (e.g., HMOs) insert the following paragraph :*
>
> Starting {insert effective date}, you must receive your regular Medicare services and other covered services from our doctors and hospitals. Except for maintenance dialysis when you are away from home, and emergencies and urgently needed care, all your medical care must be provided or approved by {insert organization and/or plan name}. If you receive regular health care services from doctors or clinics that are not part of {insert organization and/or plan name}, neither Medicare nor {insert organization and/or plan name} will pay for these services.
>
> <u>Note 2:</u> *All open network plans (e.g., PPOs, HMOs with POS option, etc.), not including PFFS plans, insert the following paragraph:*
>
> Starting {insert effective date}, you should receive your Medicare services and other covered services from our doctors and hospitals. If you receive health care services from doctors or clinics that are not part of {insert organization and/or plan name}, you will have to pay more for these services.
>
> <u>Note 3:</u> *All PFFS plans, insert the following paragraph:*
>
> Starting {insert effective date}, you should receive your Medicare services and other covered services from our doctors and hospitals. You have the right to request a written confirmation of whether services or treatments will be covered by us. Call us at {insert phone number} to ask for this information.

Until your {insert organization and/or plan name} membership card arrives, you can use this letter as if it were a membership card. The Evidence of Coverage booklet explains how to get the medical services you need from {insert organization and/or plan name}. Information on how to get your medical care at {insert organization and/or plan name} *{also insert the following phrase if appropriate for your plan: "and on how to choose a primary care doctor"}* is attached here.

The Health Care Financing Administration (HCFA), the federal agency that runs Medicare, must also approve your application to become a member of {insert organization and/or plan name}. We will write to you as soon as HCFA approves your application. Until then, you should keep any Medicare supplemental policy that you have, including Medigap or Medicare Select.

For HCFA to approve your application, you must have Medicare Part A and Part B coverage. If

you do not have Medicare Part A and Part B, or if there is any other reason why HCFA cannot approve your application to {insert organization and/or plan name}, we will write to you and tell you the reasons. If HCFA does not approve your application, we may have to bill you for services you have received from {insert organization and/or plan name}.

If you have any questions, please call us at {insert phone number} or TTY/TDD {insert phone number}.

Sincerely,

{insert name and title}

Attachment

Confirmation of Enrollment

Dear {insert beneficiary name}:

The Health Care Financing Administration (HCFA), the federal agency that runs Medicare, has approved your application to {insert organization and/or plan name}. As of {insert effective date}, you are a member of {insert organization and/or plan name}.

> *<u>Note 1:</u> All closed network plans (e.g., HMOs) insert the following after the above sentence:*
>
> This means you must receive your regular Medicare services and other covered services from our doctors and hospitals. Except for maintenance dialysis when you are away from home, and emergencies and urgently needed care, all your medical care must be provided or approved by {insert organization and/or plan name}.
>
> *<u>Note 2:</u> All open network plans (e.g., PFFS plans, PPOs, HMOs with POS option, etc.), insert the following after the above sentence:*
>
> This means you should receive your Medicare services and other covered services from our doctors and hospitals.

Please be sure to show your {insert organization and/or plan name} membership card when you get medical services. If you have not received your card, please call us. In the meantime, you can use this letter as proof that you belong to {insert organization and/or plan name}. When your card arrives, use it each time you visit our doctors and clinics.

Now that you are in a Medicare plan, you do not need any extra insurance coverage. You may want to cancel any Medicare supplemental policies that you have, including Medigap or Medicare Select.

If you have any questions, please call us at {insert phone number} or TTY/TDD {insert phone number}.

Sincerely,

{insert name and title}

M+C Organization Denial of Enrollment (Manual Version)

Dear {insert beneficiary name}:

Thank you for your application to join {insert organization and/or plan name}. We are sorry to tell you that we cannot accept your application. The reason or reasons are checked below:

1. _____ You do not have Medicare Part A

2. _____ You do not have Medicare Part B

3. _____ You have End Stage Renal Disease. This is permanent kidney failure. You would need regular dialysis or a kidney transplant to stay alive.

4. _____ Your permanent address is outside our service area

5. _____ We wrote to you on {insert date of letter} asking for more information, but we did not receive it by the date we said we needed it.

6. _____ {insert organization and/or plan name} is not accepting new members for the {insert plan name} now. We will open for new applications in {insert date plan re-opens for enrollment}.

7. _____ Other {explain}: _____

If number l, 2, or 3 is checked and this information is not correct, you should contact your local Social Security office and correct this wrong information. Once you have corrected this information, please call us if you want to apply again to {insert organization and/or plan name}.

If you have received any medical services through {insert organization and/or plan name}, we may have to send you a bill for those services

If you have any questions, please call us at {insert phone number} or TTY/TDD {insert phone number}.

Sincerely,
{insert name and title}

M+C Organization Denial of Enrollment (Automated Version)

Denial List (for reference in automating this letter):

1. You do not have Medicare Part A
2. You do not have Medicare Part B
3. You have End Stage Renal Disease. This is permanent kidney failure. You would need regular dialysis or a kidney transplant to stay alive.
4. Your permanent address is outside our service area
5. We wrote to you on {insert date of letter} asking for more information, but we did not receive it by the date we said we needed it.
6. {insert organization and/or plan name} is not accepting new members for the {insert plan name} now. We will open for new applications in {insert date plan re-opens for enrollment}.
7. If none of the above reasons can be used, insert language to explain reason for denial.

Dear {insert beneficiary name}:

Thank you for your application to join {insert organization and/or plan name}. We are sorry to tell you that we cannot accept your application.

We are unable to accept your application because {insert reason, using the language from the above "Denial list"}.

> *NOTE: If the reason for rejection is number l, 2, and/or 3 from the above "Denial list," insert the following paragraph. Depending on the reason(s) for denial, begin the paragraph with the following phrase:*
>
> *For rejection reason #1:* If you have Medicare Part A,
> *For rejection reason #2*: If you have Medicare Part B,
> *For rejection reason #3:* If you do not have End Stage Renal Disease,
>
> *Given that more there can be more than one rejection reason, the above phrases can be combined. For example, the notice may say, "If you have Medicare Part A and Part B,"*
>
> *Finish the phrase with the following language:* you should contact your local Social Security office to correct their wrong information. Once you have corrected this information, please call us if you want to apply again to {insert organization and/or plan name}.

If you have received any medical services through {insert organization and/or plan name}, we may have to send you a bill for those services

If you have any questions, please call us at {insert phone number} or TTY/TDD {insert phone

number}.

Sincerely,

{insert name and title}

HCFA Rejection of Enrollment (Manual Version)

Dear {insert beneficiary name}:

Thank you for your application to join {insert organization and/or plan name}. We are sorry to tell you that we cannot accept your application. The Health Care Financing Administration (HCFA), the federal agency that runs Medicare, said the reason or reasons you cannot join {insert organization and/or plan name} are checked below:

1. _____ You do not have Medicare Part A

2. _____ You do not have Medicare Part B

3. _____ You have End Stage Renal Disease. This is permanent kidney failure. You would need regular dialysis or a kidney transplant to stay alive.

4. _____ You applied to join another Medicare managed care plan at the same time you applied to {insert organization and/or plan name}. All of your applications are rejected. This means you are still covered by original Medicare or the Medicare plan you were in before you applied to {insert organization and/or plan name}.

If number l, 2, or 3 is checked and this information is not correct, you should contact your local Social Security office and correct this wrong information. Once you have corrected this information, please call us if you want to apply again to {insert organization and/or plan name}.

If number 1, 2, 3, or 4 is checked and this information is correct, we may send you a bill for any medical services you received from {insert organization and/or plan name} since {insert effective date given to beneficiary}.

If you have any questions, please call us at {insert phone number} or TTY/TDD {insert phone number}.

Sincerely,

{insert name and title}

HCFA Rejection of Enrollment (Automated Version)

Rejection List (for reference in automating this letter):

1. You do not have Medicare Part A
2. You do not have Medicare Part B
3. You have End Stage Renal Disease. This is permanent kidney failure. You would need regular dialysis or a kidney transplant to stay alive
4. You applied to join another Medicare managed care plan at the same time you applied to {insert organization and/or plan name}. All of your applications are rejected. This means you are still covered by original Medicare or the Medicare plan you were in before you applied to {insert organization and/or plan name}.

Dear {insert beneficiary name}:

Thank you for your application to join {insert organization and/or plan name}. We are sorry to tell you that we cannot accept your application.

The Health Care Financing Administration (HCFA), the federal agency that runs Medicare, said the reason {replace "reason" with "reasons" if appropriate} you cannot join {insert organization and/or plan name} is {replace "is" with "are" if appropriate} are {insert reason, using the language from the above "Rejection list"}.

NOTE 1: If the reason for rejection is number l, 2, and/or 3 from the above "Rejection list," insert the following paragraph. Depending on the reason(s) for rejection, begin the paragraph with the following phrase:

For rejection reason #1: If you have Medicare Part A,
For rejection reason #2: If you have Medicare Part B,
For rejection reason #3: If you do not have End Stage Renal Disease,

Given that more there can be more than one rejection reason, the above phrases can be combined. For example, the notice may say "If you have Medicare Part A and Part B,"

Finish the phrase with the following language: you should contact your local Social Security office and correct their wrong information. Once you have corrected this information, please call us if you want to apply again to {insert organization and/or plan name}.

NOTE 2: If the reason for rejection is number l, 2, 3, and/or 4 from the above list, insert the following paragraph.

We may send you a bill for any medical services you received from {insert organization and/or plan name} since {insert effective date given to beneficiary}.

If you have any questions, please call us at {insert phone number} or TTY/TDD {insert phone number}.

Sincerely,

{insert name and title}

Request for more information to process enrollment (Manual Version)

Dear {insert beneficiary name}:

We received your application to {insert organization and/or plan name}. We cannot process your application until we get more information from you. Please send us the item or items that are checked below:

1. _____ A copy of your Medicare health insurance card, or your Letter of Medicare Verification from the Social Security Administration or Railroad Retirement Board. We need to make sure that you have both Medicare Part A and Part B coverage.

2. _____ A copy of your Durable Power of Attorney papers or other legal papers authorizing another person to act on your behalf.

3. _____ Your signature on the application. Your application is enclosed here. Please sign it on the last page, write the date, and send it back to us.

4. _____ A copy of any document that shows your permanent address. This can be a utility bill, your driver's license, a county tax bill, your voter's registration, or something that has your address on it.

5. _____ Other {*explain*} _____

Please send or bring this information to us at {insert mailing address} by {insert date information due}. A stamped envelope, addressed to us, is enclosed for you to use. If we do not receive this information by {insert date information due}, we must deny your application to join {insert organization and/or plan name}.

If you have any questions, please call us at {insert phone number} or TTY/TDD {insert phone number}.

Sincerely,
{insert name and title}

Request for more information to process enrollment (Automated Version)

Information List (for reference in automating this letter):

1. A copy of your Medicare health insurance card, or your Letter of Medicare Verification from the Social Security Administration or Railroad Retirement Board. We need to make sure that you have both Medicare Part A and Part B coverage.
2. A copy of your Durable Power of Attorney papers or other legal papers authorizing another person to act on your behalf.
3. Your signature on the application. Your application is enclosed here. Please sign it on the last page, write the date, and send it back to us.
4. A copy of any document that shows your permanent address. This can be a utility bill, your driver's license, a county tax bill, your voter's registration, or something that has your address on it.
5. If non of the above reasons can be used, insert language to explain type of information needed.

Dear {insert beneficiary name}:

We received your application to {insert organization and/or plan name}. We cannot process your application until we get more information from you.

Please send us {insert information needed, using language from above "Information list"}.

Please send or bring this information to us at {insert mailing address} by {insert date information due}. A stamped envelope, addressed to us, is enclosed for you to use. If we do not receive this information by {insert date information due}, we must deny your application to join {insert organization and/or plan name}.

If you have any questions, please call us at {insert phone number} or TTY/TDD {insert phone number}.

Sincerely,

{insert name and title}
